Utah DHS-DCFS Form 984 **HEALTH VISIT REPORT** Rev May 2008

Child's Name_____ **D.O.B.**_____ **Current Age**_____

Date of Visit: _____ **Medicaid ID Number**_____

Attending visit: Parent Foster Parent Tracker Other: **Caseworker Name**_____

Select Visit Type: WCC Sick Visit Dental/Ortho Mental Health/Therapy Med Mgmt. Other:_____

Wt._____ Ht._____ BMI_____OFC____ ____%

T_____ B/P_____/_____ P_____ RR_____

Vision Screen: **OD** 20**/** **OS** 20/ **OU** 20/

Lab tests: Hgb/Hct UA HCG STI PPD Other**:**
Results:
Pertinent Past History:

Allergies: NKMA PCN Sulfa Other:_____

Review of Systems/ Physical Exam

CIRCLE: N - Normal **D**- Deferred **A -**Abnormal(**describe if abnormal**)

Growth/Dev: N D A_____
Head: N D A_____
Eyes: N D A _____
Ears: N D A _____
Nose: N D A _____
Throat: N D A _____
Pulmonary: N D A_____ _____
Cardiac: N D A _____
G.I.: N D A _____
G.U.: N D A _____
Pelvic: N D A_____
Musculo/Skeletal: N D A_____
Skin: N D A_____

Immunizations Given: Hep B Hep A MMR MMRV Varicella Tdap DTap Td HPV Menactra PCV RGE Prevnar IPV HIB Flu Other: _____

Diagnosis:

Plan:
Medications:(please list):

Treatments:

Follow-up/Referrals:
(Next available appointment will be scheduled unless noted it is urgent.)

Next Appointment:

Did you have enough information for the care of this child YES NO

Print Medical Provider Name/Facility_____

NPI #_____ Office Phone Number_____

Health Provider Signature_____ Date_____

White Copy - DCFS FHC Program Yellow – Child's Home Binder Pink – Medical Provider